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State-Based Reform Efforts

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Senator Lincoln and Senator Grassley, thank you for inviting me to testify before you today. This "Prepare to Launch" Summit is a historic, bipartisan departure from how things went in 1992–94, and seems exceptionally well-designed to jump start a successful and long overdue national conversation about health system reform. I applaud you both and the other members of the committee, especially Chairman Baucus, for organizing this event and for your personal steadfast leadership in health policy.

My name is Len M. Nichols and I direct the Health Policy Program at the New America Foundation, a non-profit, non-partisan public policy research institute based in Washington, D.C., with offices in Sacramento, California. Our program seeks to nurture, advance, and protect a fact- and logic-based conversation about comprehensive health care reform. We remain open minded about the means, but not the goals: all Americans should have insured access to high-quality, affordable health care, delivered within a patient-centered system that is sustainable economically and politically. Members of our California team worked in tandem with me and my colleagues here in D.C. to provide policy development advice and research support to policy makers and opinion leaders throughout the recent reform efforts in California. You have asked me here today to report on that experience and to highlight the most salient lessons from the California effort for the nation as a whole.

Although the compromise proposal did not ultimately become law, the recent efforts in California hold important lessons and considerable hope for health policy leaders in Washington. The reform process in California showed that we can change our approach to health care politics and craft bipartisan policy solutions, we can build broad stakeholder coalitions, and we can engender durable public support. Events and realities in California, however, also remind us that political and fiscal challenges to successful reform are real and must be attended to seriously.

A more sustainable health system that better serves all Americans is both a moral and an economic imperative for our country. Rising health care costs impede access for a growing share of working families, and health costs are also the single greatest source of fiscal stress for federal, state, and local budgets. At the same time, employer-borne health care costs undermine the global competitiveness of U.S. businesses and threaten the stability of high-wage American jobs. We need to learn all we can from California and apply these lessons to achieve successful national reform. Our nation cannot afford to wait much longer.

California Policy

In January 2007, on the heels of Massachusetts' celebrated reform successes, Governor Arnold Schwarzenegger unveiled a comprehensive health care plan that aimed to provide quality, affordable health insurance to all Californians. More ambitious than Massachusetts because of the scale of the problems (e.g., roughly twice the percentage of

Californians are uninsured as are residents of Massachusetts), Schwarzenegger built his plan on a similar foundation of individual responsibility, emphasizing prevention and wellness and included an individual requirement to purchase coverage. Most impressive, however, was his unique approach to sharing responsibility for financing reform among an unprecedentedly diverse group of stakeholders.[1]

After almost a year of negotiations between Governor Schwarzenegger and Democratic legislative leaders, compromise legislation with a framework and goals similar to the governor's original proposal passed the State Assembly with a large majority.[2] This compromise legislation, however, was later defeated by the California Senate's Health Committee.[3]

Both the governor's initial proposal and the subsequent compromise legislation were similar in many respects to proposals put forward recently by federal lawmakers, other state lawmakers, and stakeholder groups elsewhere. The California legislation included several elements that make up the current model proposal to cover all Americans through private insurance markets. These elements include: insurance market reforms, subsidized coverage for low-income individuals, an individual mandate to purchase insurance, and efforts to enhance the delivery system and improve quality.[4] I have included a more detailed explanation of the California legislation in Appendix 1.[5]

Achievements of the California Effort

While the effort to reform California's health system ultimately did not succeed, the process did show that it is possible to foster the sort of cooperation and coalition-building that will be necessary to pass health reform elsewhere. The negotiations between Governor Schwarzenegger and Assembly Speaker Núñez are proof that bipartisan policy processes that achieve broad stakeholder and public support are indeed feasible. A recently published study of major health legislation efforts concluded that success requires bipartisan leadership and buy-in from the stakeholder groups which helps earn essential public support as well.[6]

Bipartisan Leadership—Melding Policy and Politics

Both Governor Schwarzenegger and Assembly Speaker Núñez displayed high levels of bipartisan leadership and political courage during the health reform debates in California. Schwarzenegger stood up to withering ideological attacks from the extreme wing of his own party to accept the market regulations necessary to make the market for all, not just for the healthy. He made covering every Californian a priority and was honest about the scale of revenue necessary to sustainably finance reform. On his side of the aisle, Núñez faced down a very strong single payer lobby and unreliable cooperation from Democratic Senate leadership. He embraced the use of private markets and the individual mandate within the context of insurance reforms and affordability standards, over the objections of some of his strongest supporters who prefer both government insurance programs and increased reliance on employer financing. Similar kinds of pressures from both parties' extremes will be present in any serious national conversation about health reform.

On the national level, bipartisan support requires that each party sees its core values in the policy outcome. For Democrats it means that the solution must be effective and affordable for all Americans, especially the most vulnerable. For Republicans this means that market competition, choice, and budget constraints must play a central role. I believe that these are complimentary, not competing visions, and the contours of the California compromise show why. It IS possible to set reasonable rules so that private markets work for all Americans, and to design effective subsidy programs that do not bankrupt our nation. We can sustainably finance reform while bending the cost growth curve over time. Indeed, the cost of doing nothing—in lost jobs, coverage, and growing cost shifts to help finance care for the un- and underinsured—may be far higher than the costs of investing in reform, as California is learning today.

On a more technical level, Senate procedure necessitates a bipartisan legislative approach. As everyone here knows firsthand, the Senate requires 60 votes to achieve cloture and end a filibuster. I believe that achieving 60 votes will likely mean 70 or more Senators will need to agree that the specific proposal in question is an acceptable way to reorganize our health system. In other words, much more than token bipartisanship is required. While the 60-vote threshold is certainly demanding, I believe it will challenge us to develop innovative policy solutions that can be attractive and sustained over time, politically as well as economically.

The good news is that bipartisan leadership is far more evident today than it was prior to the 1993–94 health reform conversation. In Congress, Senators Ron Wyden (D-OR) and Bob Bennett (R-UT) along with 12 co-sponsors, 6 from each side of the aisle, have crafted the first bipartisan, bicameral effort that would cover all Americans.[7] Representatives Jim Langevin (D-RI) and Christopher Shays (R-CT) have also introduced bipartisan legislation that would guarantee all Americans quality affordable coverage.[8] After years of working hard on competing bills, Senators Blanche Lincoln (D-AR) and Richard Durbin (D-IL) have teamed up with Senators Olympia Snowe (R-ME) and Norm Coleman (R-MN) to champion a bipartisan, bicameral effort that would give small businesses and their employees access to quality affordable health care.[9]

In addition, for the first time in recent memory, the major candidates on both sides of the aisle are emphasizing policy solutions that would expand access to health coverage and control health care spending over time.[10] While their approaches may vary, the overarching takeaway at this point in the campaign is that both Republicans and Democrats seem to agree that we need to find a way to make health care more affordable and to create a more sustainable delivery system. This is progress. But we must build on this progress and close the deal in the next Congress. Too many uninsured Americans and struggling small businesses have waited too long already.

Coalition Building

California's health reform efforts united a disparate group of policy advocates representing consumers, patients, workers, large and small employers, hospitals, insurers, and faith communities.

Most surprising was the support of the hospitals and insurers. The California Hospital Association (CHA) threw its support behind the plan despite the fact that it included a four percent tax on hospital revenue to finance reform.[11] Nonetheless, the CHA believed they would receive more insured patients under the plan and were motivated by an increase in reimbursement rates for services provided to Medicaid beneficiaries.[12]

Meanwhile, six of California's major insurers—Aetna, Blue Shield of California, CIGNA, Health Net, Kaiser Permanente, and UnitedHealthcare—also agreed to the reforms necessary to cover all Californians.[13] As Blue Shield CEO, Bruce Bodaken, said in a recent *Health Affairs* article,

> "Although the proposal contradicts basic and long-standing principles of the health insurance business, six of California's seven largest health plans worked with policymakers to flesh out a workable proposal in this area. Aetna, Blue Shield of California, CIGNA, Health Net, Kaiser Permanente, and UnitedHealthcare met repeatedly with staff for the governor and legislature on provisions to minimize the market disruption in connection with these underwriting and rating reforms."[14]

If these insurers were supportive in California, will they support reform elsewhere? Aetna, Cigna, and Health Net are all for profit companies, and Aetna, Cigna, Health Net, Kaiser Permanente, and UnitedHealthcare all sell insurance outside of California.[15] Furthermore, Aetna, Kaiser Permanente, and several Blue plans have endorsed the idea of an individual mandate.[16] This proves that there are some insurers willing to transition their business models towards delivering high value, efficient care, and away from selecting risk.

Less surprising, but no less essential, was the support that emerged from consumer (American Association of Retired Persons (AARP), Consumers Union, and Health Access California) and labor groups (Service Employees International Union (SEIU), the California State Council of Carpenters, and the American Federation of State, County and Municipal Employees (AFSCME)).[17] It is important to note here that many of these organizations have at times favored a single payer approach. Their eventual support for the California compromise effort signaled a general willingness to get things done and make meaningful progress towards a long sought after goal.

In addition, high-profile segments of the large and small business community also lined up behind the plan.[18] Business groups were particularly drawn to the governor's "hidden

tax" argument—those with insurance pay higher premiums because of cost-shifting by providers as a result of uncompensated care for the uninsured.[19]

Is this kind of coalition-building possible on the national level? Anyone who remembers the 1993–94 health reform conversation can recall the decisively negative and eventually detrimental impact many interest groups had on the tone and progress of the debate. If you survey the national landscape today, however, several "unlikely bedfellow" coalitions have emerged in support of comprehensive reform. Groups like Divided We Fail (Business Roundtable, AARP, SEIU, and National Federation of Independent Businesses) and Better Health Care Together (Wal-Mart, AT&T, SEIU, Center for American Progress, and others) have spearheaded efforts to push health care reform to the top of the national agenda.[20] In addition, high profile organizations like the Federation of American Hospitals, the ERISA Industry Committee, the Committee for Economic Development, and Advamed have all released plans with similar features that would ensure all Americans have quality, affordable health coverage.[21]

In California and the nation, especially when compared to 16 years ago, there is a growing consensus, especially among business leaders, that the status quo is unsustainable.[22] In addition, the rising cost of health care is affecting more and more Americans. Since 1987, the cost of the average family health insurance policy has risen from 7 percent of median family income to 17 percent.[23] So while many organizations may not have settled on a specific preferred policy approach today, they can agree that just saying "no" is no longer an option. The President and CEO of the National Federation of Independent Business (NFIB), Tod Stottlemeyer, captured this issue as he launched NFIB's health care campaign,

> "In 1994, NFIB fought against a comprehensive healthcare reform package because it did not adequately consider the needs of the small business community. Today is 2008, and the healthcare situation has gotten much worse, especially for small business. Back then it was enough to 'just say no' to bad policy, but now we have an obligation to these hard-working people to push our nation's leaders to find a solution that works."[24]

Public Support

The public in California strongly and consistently supported the health reform effort in general and favored the compromise legislation approved by the Assembly. In a poll conducted by the Field Research Corporation during the week of December 10–17, 2007, 64 percent of Californians said they favored the compromise reform proposal.[25] Since the legislation failed in the California Senate, that support has only grown. In a subsequent Field Research Corporation survey conducted March 12–30, 2008, 72 percent of Californians approved of the legislation developed by Governor Schwarzenegger and Assembly Speaker Núñez. In addition, an equal percentage of voters (72 percent) are concerned about the state's failure to pass health reform last year.[26]

The public wanted health reform in California. Similarly, Americans across the nation are calling for action.[27] While the economy has replaced health care as the top domestic concern among voters in some polls, many voters indicate that their concerns with the economy are linked to being able to afford health care in the future.[28]

I believe that the symbol and reality of bipartisan support helps earn the public's trust for specific legislative approaches to issues as complex as health reform. A proposal without bipartisan support can be dismissed too easily as "more of the same" Washington (or Sacramento) politics, the very kind of politics that voters in both parties seem to want to move beyond in this election cycle.

Challenges to Reform

There were several legislative, political, fiscal, and demographic challenges that hindered the California reform effort that were unique to the state. In addition, there were additional challenges encountered in California that will likely be systemic to any health reform effort.[29] I will focus my testimony on two particular challenges that were devastating in California: ideological politics and the complexity of financing reform in tough economic times.

Ideological Politics

In spite of strong, bipartisan leadership, partisan ideological politics also played key roles in derailing California reform. Soon after the governor announced his ambitious plan in 2007, the leader of Americans for Tax Reform, Grover Norquist, presented California Republicans in the legislature with an anti-tax pledge promising no tax increases under any circumstances. The pledge was signed by all but one of California's Republican legislators.[30] This commitment, and California budget rules that invalidate revenue raising statutes unless they secure 2/3 of the possible number of votes, made it impossible for the governor and Republican legislators to engage in a serious conversation about health reform. It also meant that a ballot initiative would be required to raise the revenue required to finance reform, which complicates both legislation implementing reform and the process of designing and securing a financing package.

However, staunch ideological positions were not limited to Republicans. The single payer community in California is highly focused, well organized, and much of it is absolutely unwilling to compromise. Led by Senator Sheila Kuehl, chair of the Senate Health Committee, single payer advocates aggressively opposed the efforts of Governor Schwarzenegger and Assembly Speaker Núñez to fashion a compromise using private insurance markets and market incentives in general. This opposition created debilitating conflict among erstwhile supporters of reform, and seriously delayed the legislature's deliberations as the economy drifted from strong to weak. Senator Kuehl's committee dealt the death blow to the compromise for California reform by voting it down 7-1 after a very one-sided hearing and debate.

However devoutly we may wish otherwise, ideological opponents are not going to cede health reform to health policy experts or reasoned debate. Therefore, for health reform to be possible on a national level, lawmakers must be willing to ignore calls for ideological purity from within their own party and to work together to serve our common goals and the national interest. With tenacity and as much grace as possible, lawmakers willing to work together must be prepared to deflect attacks from those who intend to distract people from considering the facts and finding common ground. Our health care problems are not inherently partisan. The cry of a child in pain is not a partisan sound. The fear of financial ruin because a breadwinner is too ill to work and maintain insurance is not a partisan emotion. The worry of a small business owner who cannot afford ever-rising health insurance premiums is not a partisan nightmare. Our nation's health care crisis affects every American—Republican, Democrat, or Independent. The problem is not partisan and neither is the solution. We have let the extremes prevent reasoned compromise for far too long.

Complexity of Financing Reform in Tough Economic Times

When Schwarzenegger proposed his reform package in January 2007, the state's economy and fiscal outlook were strong. By the time the Senate began to take up the question 14 months later—delayed as it was by stalling tactics by opponents from both ideological extremes (Republicans stalled on the overall budget for the year and Democrats delayed considering realistic private market solutions)—the economy and budget forecasts had weakened considerably. On the day the Senate Health Committee effectively ended the comprehensive reform debate in California, the state was projected to be facing a $14.5 billion budget deficit. This fact provided convenient intellectual cover for Democrats who preferred to kill private, market-based reform by pleading (newly acquired) fiscal responsibility. Pointing to the budget deficit allowed them to hide an uncompromising willingness to tolerate six million uninsured Californians (and all the economic problems that entails) while waiting for their fellow citizens to finally agree to implement single payer.[31]

On the national level, it would be easy for naysayers and opponents of reform to conclude from California (and our own national fiscal challenges) that our nation simply cannot afford serious reform to our health system. I submit to you that our nation cannot afford to postpone health reform any longer. The opportunity cost of doing nothing is very high indeed.

Consider this. The income and productivity our economy loses every year—because of the poor health and shorter lifespan of the uninsured—is as much as and perhaps greater than the public cost of covering all Americans (between $102 and $204 billion).[32] This Institute of Medicine-based estimate does not take into account "spillover costs." For example, uninsured parents who lose time from work or even their lives have a hugely negative impact on their children, and unnecessarily sick workers hamper the productivity of their colleagues. The total financial impact of the uninsured on our economy is likely far greater than the costs of covering them.[33]

Moreover, the excess burden that our inefficient health system plus our relative reliance on employer financing impose on U.S. firms engaged in global competition threatens the future of good high-value added jobs. Manufacturing firms in the United States pay more than twice as much in hourly health costs as their major trading partners—$ 2.38 per worker per hour versus $0.96.[34] In addition, globalization makes it impossible for firms to shift health care costs into the prices of their goods. And labor market competition makes it hard to shift all of recurrent, high and variable premium inflation directly into wages in one year. As a result, employers are reducing or eliminating health benefits and workers are paying a larger share of the bill. Since 2000, the percentage of employers offering health benefits declined from 69 percent to 60 percent.[35] Over the same period, the average worker contribution for family coverage increased by 102 percent, while average wages only increased by three percent.[36] I believe this is precisely why employers are so hyper-focused on finding a sustainable solution—their short-run balance sheets are telling them they must do something.

Rising health care costs are placing increasing strain on federal, state, and local budgets. The cost of health care is threatening the sustainability of the Medicare and Medicaid programs. As Peter Orszag said recently, "The nation's long-term fiscal balance will be determined primarily by the future rate of health care cost growth."[37] He has also said that rising health care costs, not the retirement of the baby boomers, pose the biggest threat to the Medicare program.[38] On the most fundamental level, we must control health care cost growth in order to preserve our nation's ability to care for our most vulnerable. Thus, the solution to entitlement reform is health system reform.

Recessions do affect budget deficits, but please consider these facts. In January of 1993, when Bill Clinton took office and began work on his administration's health reform plan, the deficit was equal to five percent of GDP. When he left office in January of 2001, after rather different economic and fiscal policies than we have enjoyed lately, the *surplus* was two percent of GDP. That is a seven percentage point swing in budget deficit/GDP ratios. Conservative estimates of the public cost of covering all Americans are no more than 1 percent of GDP ($140B). Recessions should not deter us from health reform.

On the delivery system side, the opportunity cost of doing nothing may be even greater. Recently the National Academy of Engineering and the Institute of Medicine estimated that the amount of health spending that adds no discernible clinical value is about 30 percent of the total.[39] This is equal to five percent of GDP. Thus, reorganizing our delivery system to take better advantage of information systems and incentive reforms is not only imperative, it could yield huge returns. Note first that reducing just 20 percent of the waste in our system today would pay for covering the uninsured.

But the interesting possibilities come from reducing waste systematically over time. Suppose we could use an electronic information infrastructure[40], wholesale payment reforms like those being discussed in medical home and bundled payment experiments, and increasing the production and reliance upon "best practice" information to reduce just 10 percent of our current waste each year for the next 10 years. By 2018, we would have reduced health spending by $900B over baseline. That would be $900B we could devote

to investment in economy-wide productivity enhancing technologies, green technologies, education, public infrastructure, etc. The opportunity cost of failing to pursue delivery system reform now is huge.

Finally, a recent letter from the Congressional Budget Office assesses the Healthy Americans Act (S. 334) and concludes that it would be roughly revenue neutral in its first full year of implementation.[41] This estimate serves as additional proof that we can afford comprehensive health reform if we pursue it wisely, mindful of key tradeoffs.

Thank you for inviting me to testify here today. I am honored to come before a Congress and Committee that seems poised to consider serious efforts to reform our health system. I am heartened that we have been able to learn so much from such catalytic and heroic efforts in states like California. I would be glad to answer any question my remarks may have provoked, today or at a time of your convenience.

Appendix 1. Elements of California Reform Plan

Coverage Expansion and Delivery System Reform

A new insurance marketplace. By requiring insurers to sell to all individuals regardless of health status, the legislation would have made private markets work for all Californians. In the context of a purchase mandate, this rule would have led to reduced underwriting and selling costs.

Sliding scale subsidies. The compromise legislation included sliding scale subsidies for families with incomes of up to 250 percent of the federal poverty level, or $51,625 for a family of four. It also included sliding scale tax credits designed to limit premiums to 5.5 percent of income for individuals with incomes of up to 400 percent of the poverty level.

Expanded government insurance programs. The compromise legislation expanded income eligibility for both Medicaid (Medi-Cal) and the State Children's Health Insurance Program (SCHIP or Healthy Families in California).

An individual mandate. Once supported by sliding scale subsidies and insurance market reforms, all Californians would have been required to obtain either public or private health insurance coverage.

Efforts to reform the delivery system and enhance quality. The legislation required all health plans to offer a benefit package that included incentives linked to healthy behavior and chronic care management. It also encouraged the development and implementation of health information technology.

Financing

Federal matching funds. The proposed plan included expanded coverage under Medi-Cal, California's version of Medicaid, and Healthy Families, California's SCHIP program. In addition, the plan increased Medi-Cal provider payment rates. Federal matching allotments and higher Medi-Cal reimbursements were central to the financing plan.

Hospital fees. Under the proposed plan, hospitals would have admitted greater numbers of insured patients in return for higher Medi-Cal reimbursement rates. In exchange for these provisions, the California Hospital Association agreed that hospitals would contribute four percent of gross revenues toward the health plan. Governor Schwarzenegger initially imposed a two percent gross revenue fee on physicians, but this proposal was met with intense opposition and dropped from consideration by the legislature.

Employer participation. All employers would have been required to participate in the health insurance market through a "pay or play" provision. Under this provision,

employers could either offer health coverage to their workers (play) or be required to pay a sliding-scale fee of between 1 percent and 6.5 percent of their total payroll.

Tobacco tax. The compromise legislation required a $1.75 cigarette tax hike.

Given California's budget rules the revenue provisions of the legislation would have been subject to public approval on the November 2008 ballot.

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